



6 January 2012

Dr Ian Holland  
Committee Secretary  
Senate Standing Committees on Community Affairs  
PO Box 6100  
Parliament House  
CANBERRA ACT 2600

Dear Ian

Please find attached the Alliance's Submission to the Community Affairs References Committee Inquiry into *Factors affecting the supply of health services and medical professionals in rural areas*.

Thank you for the opportunity to make this submission after the initially publicised closing date.

You will understand that the topics covered by this Inquiry are of the greatest interest to the people of rural and remote Australia and therefore to the National Rural Health Alliance. Our submission comprises a new 13-page overview and a significant number of attachments, being documents produced at an earlier time relating to one or more aspects of the Inquiry's terms of reference.

We are providing all of these documents in the belief that they will be of interest to the Committee - but perhaps we should apologise for the length of the total submission that therefore results! It is worth making the point that each of these documents represents the agreed position of those national organisations which were members of the Alliance at the time of its publication. (There has been some growth in the number of member bodies in the Alliance, from the 25 in 2005 to the 32 today.)

We would like to particularly draw your attention to the 2008 submission on RRMA which will be of special interest to the Committee given its Terms of Reference.

Please be assured of our strong ongoing interest in the work of the Committee.

Thank you for your consideration.

Best wishes

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## **Submission to the Senate Community Affairs References Committee**

### **Factors affecting the supply of health services and medical professionals in rural areas**

**6 January 2012**

*This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.*

## **Factors affecting the supply of health services and medical professionals in rural areas**

### **Summary**

The National Rural Health Alliance is comprised of 32 Member Bodies, each a national body in its own right, representing rural and remote health professionals, service providers, consumers, educators, researchers and Indigenous health organisations (see Attachment 1).

The vision of the Alliance is good health and wellbeing for people living in rural and remote Australia. Its particular goal is equal health for all Australians by 2020. Underlying the Alliance's work is a belief in the importance of person-centred care.

The Alliance particularly welcomes this Inquiry's focus on small regional communities. Insufficient national recognition is given to the fact that there is a general downward gradient in health and health services from major cities to remote areas: the more remote the community, the poorer the health status of its people and the less access it has to health services and health promoting infrastructure. This is accompanied by a similar gradient where many health risk factors are concerned: for instance, the more remote the community, the lower the income, educational status and employment opportunity of its residents.

The distinction made in this Inquiry's terms of reference, between small regional communities on the one hand and major regional and metropolitan centres on the other, is entirely appropriate.<sup>1</sup> In terms of access to health service and other lifestyle opportunities, major regional centres offer a range of services and facilities not too unlike those available in the capital cities.

The Alliance also particularly welcomes this Inquiry's emphasis on the full range of health professionals, described in its terms of reference as "medical, nursing and allied health professionals". A complete list would include oral health and pharmacy professionals, neither of whom are accustomed to being considered as 'allied health', midwifery (as a separate profession from nursing), as well as health service managers - often the forgotten professionals where the delivery of safe and effective health services is concerned.

A great deal is expected of the new Medicare Locals that have been or are being established - and of the Local Health (or Hospital) Networks which will take the running on acute or hospital services. Among those expectations are that the Medicare Locals will have the capacity to identify local service gaps and then move, by whatever means, to fill those gaps. Because of the central importance of general practice in providing and coordinating primary care, it is certain that shortages of medical practitioners in any particular Medicare Local area will be a priority for it. However, whether rural Medicare Locals, either individually or as a group, can find a solution to the challenge of sourcing and retaining sufficient GPs - a solution that has proved very elusive at national and state levels - remains to be seen.

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<sup>1</sup> In this submission, most of the references to rural or urban figures are based on the five-point ASGC-RA scale which has Major cities as 1, Inner regional as 2, Outer regional as 3, Remote as 4 and Very remote as 5. However there is considerable and common ambiguity associated with the word 'regional', with the word relating **either** to a form of governance (as in 'national', 'state', 'regional') **or** to a description of those places outside major cities. For greater clarity, this submission (and the Alliance more generally) adopts a usage which supposes a bimodal nation with 'major city' on one side and 'rural and remote areas' on the other.

The Inquiry's considerations relating to Medicare Locals should take account of their effect on the provision of health services across the board in rural areas, not just on their effect on the provision of medical services. One of the contributing factors to the decision of general practitioners to move to or stay in a rural area is the extent to which they have local support from other health professionals.

The third element of the Inquiry's terms of reference relates to "current incentive programs for recruitment and retention of doctors and dentists, particularly in smaller rural communities". There is a large number of programs in place relating to some stage of an individual's journey from medical student, through vocational medical training, to sustained and ongoing medical practice in a rural area. An exact count of such programs may be difficult but it has been said that they are over 50 different programs aimed at having impact on one or more of the stages of this medical pathway.

Where dentists, allied health professionals, nurses, midwives and managers are concerned there are many less. One of the Alliance's long-standing aspirations is that, without diminishing existing rural medical support, there should be greater equivalence of support across all health professions than is currently the case, and at all stages of the professional's pathway to rural practice. In building increased support for other health professionals, much can be learned from the successes and failures relating to rural general practice.

In the Department of Health and Ageing there have been many reviews of rural health programs over the years, including those for general practice, resulting in various administrative changes and rationalisations. The latest such review has resulted in the rationalisation of over 159 programs into 18 new 'flexible funds'. (This is not without its dangers for the targeting of specific programs to specific purposes.) Given all of this evaluative activity it might be assumed that the role, structure, effectiveness and appropriateness of the delivery model for rural health workforce programs are of a high order. Even if this is the case, however, there are still serious mal-distributions of health professionals.

One of the specific issues subject to this Inquiry is "whether the application of the current ASGC Remoteness Areas classification scheme ensures appropriate distribution of funds and delivers intended outcomes". The Alliance is very familiar with both the pre-existing classification system commonly used in the health sector (the Rural, Remote and Metropolitan Areas (RRMA) classification), and the Australian Standard Geographic Classification – Remoteness Areas (ASGC-RA) system. As well as its core advocacy and policy development work, the Alliance manages the Rural Australia Medical Undergraduate Scholarship (RAMUS) scheme for the Commonwealth. This RAMUS scheme used to apply RRMA to all applications but switched to ASGC-RA two years ago.

It is therefore with some confidence that the Alliance can report that, just like RRMA, the ASGC-RA classification system does result in some anomalies, many of which will no doubt be reported to this Inquiry. RRMA, which included the population size of individual communities among its criteria, also had anomalies - as indeed must be the case for any system based on segmentation of a population described according to continuous variables such as numbers of people or distance from a capital city.

The Alliance's view is that, for a number of reasons, the ASGC-RA is the most appropriate basis of a rurality classification system to be used for various purposes, including for the allocation of public resources. However it should be seen as a necessary but not sufficient part of such a classification system. For any particular purpose, ASGC-RA should be augmented by one or more additional filters or lenses suitable for that purpose. For instance, it will make sense for many purposes to add to the basic ASGC-RA ranking or score a measure of population size. Also, for access to GPs, for example, it would make sense to include the existing ratio of GPs to population as happens for the definitions of Districts of Workforce Shortage and Areas of Need.

The ASGC-RA system is the baby that needs to be clothed and fed, not thrown out with the bathwater.

### **‘Person-centred care’**

Health Workforce Australia’s consultation paper on the *National Health Workforce Innovation and Reform Strategy* states that:

"Better understanding of how the workforce can be developed to meet need and improve the outcomes valued by consumers and carers will contribute to future innovation and reform strategies across the education and health sectors."

The consultation process associated with that Strategy has consistently elicited expressions of concern that students and urban and overseas health professionals are ill-prepared for work in rural and remote areas. To overcome this challenge, the rural and remote health sector needs to train health professionals to deliver person-centred health care and to expect its service managers, health educators and academics to model and lead the necessary cultural changes. The need for person-centred care should be the guiding principle of health workforce reform and the delivery of health care.

Such an approach has been supported in a number of key documents relating to the health system. For example, the Final Report of the National Health and Hospitals Reform Commission had as its first design principle:

“The direction of our health and aged care system, the provision of health and aged care services and our efforts to strengthen wellness and prevention must be shaped around the health needs of people, their families, carers and communities. A people focus reflects not only responsiveness to individual differences, abilities and preferences, but is grounded in the social and community context of people's lives and their ability to exercise choice.”

In 2010, Australian Health Ministers endorsed the Australian Safety and Quality Framework for Health Care produced by the Australian Commission on Safety and Quality in Health Care. The Framework specifies three core principles for safe and high quality care: that care is consumer centred, driven by information and organised for safety.

In 2011 the Australian Commission on Safety and Quality in Health Care described patient-centred care as “an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among healthcare providers, patients and families”.

Health Workforce Australia's *National Health Workforce Strategic Framework for Action 2011-2015* states that:

"What is required is a paradigm shift in ways of thinking about workforce design and planning, one that works backwards from outcomes for communities, consumers and population need, versus the current thinking that is generally focussed on working forward from the base of existing professions and their interests and skills, demarcations and responsibilities."

A number of things will flow from the routine practice of person-centred care. They will include the provision of care that is culturally secure and ethnically appropriate for all; radical improvements in health literacy; and greater professional awareness of patients' needs, attitudes and concerns.

### Health workforce numbers

The attachments to this Submission include a number of documents prepared by the Alliance for other purposes and which deal with various aspects of health workforce shortages in rural and remote areas. We commend these documents to the Inquiry Secretariat and trust that they will provide useful background information.

### Doctors

The latest report on the total number of working medical practitioners in rural and remote areas compared with major cities<sup>2</sup> has been interpreted in some quarters as indicating that the nation is 'awash with doctors'.

In 2009 the total number of **full-time equivalent<sup>3</sup> medical practitioners** (specialists, hospital non-specialists, GPs) per 100,000, was 392 in Major cities, 224 in Inner regional areas, 206 in Outer regional areas, and 246 in Remote plus Very remote areas. For those who treat patients (ie subtracting the non-clinicians) the FTE numbers were 362, 215, 194 and 230 (Table 1).

**Table 1: Medical practitioners and GPs by location, 2009**

	Major city	Inner regional	Outer regional	Remote/ Very Remote
All medical practitioners	392	224	206	246
All clinical medical practitioners	362	215	194	230
'General practitioners'	110	103	106	143

As far as general practitioners were concerned (assuming the term to be synonymous with what the report describes as "primary care medical practitioners") the number of different **individuals** practising per 100,000 population was 118, 104, 99 and 126 in Major cities, Inner regional areas, Outer regional areas, and Remote plus Very remote areas respectively. However, because GPs working in Remote plus Very remote areas worked 8.3 hours per week more than those in major cities (45.6 cf 37.3 hours), these numbers for individual

<sup>2</sup> <http://aihw.gov.au/publication-detail/?id=10737419680&tab=2> AIHW 2011. Medical labour force 2009. Bulletin no. 89. Cat. no. AUS 138. Canberra: AIHW.

<sup>3</sup> at 40 hours a week

practitioners translate to **full-time equivalents** (still at 40 hours a week) of 110, 103, 106 and 143 per 100,000 residents in Major cities, Inner regional, Outer regional and Remote areas respectively<sup>4</sup>.

The figures in Table 1 also attest to the much higher proportion of medical practitioners outside the major cities who are GPs, as distinct from medical specialists or hospitalists.

The total number of medical practitioners increased consistently in the period 2002 to 2009, with the rate of increase in Outer regional and Remote/Very remote areas being considerably higher than for Major cities and Inner regional areas (Table 2).

**Table 2: All medical practitioners, FTEs (at 40 hours per week), 2002-2009**

	<b>Major city</b>	<b>Inner regional</b>	<b>Outer regional</b>	<b>Remote/ Very Remote</b>
2002	351	198	164	158
2006	374	207	173	215
2009	392	224	206	246

Consideration of simple ratios such as these does not allow for differences in health status or for differences in the scopes of practice and logistical requirements of rural/remote general practice. It is widely understood that, age-for-age, people in rural and remote areas have poorer health and worse health outcomes than people in major cities. Also, people in rural and remote areas are on average older (and therefore, other things being equal, more in need of services) than those in major cities.

The assertion that the nation is ‘awash with doctors’ is considered in greater detail below.

### **Other health professionals**

The pattern of a lower supply of medical practitioners to rural and remote (than city) areas is echoed in the patterns for other health workers, but least so for nurses. And the same reservations about the meaning or accuracy of such ratios also pertain to these other professions.

- In 2005 there were 59, 35, 29 and 20 **dentists** per 100,000 people in Major cities, Inner regional, Outer regional, and Remote areas respectively.
- In 1999 there were 82, 63, 52, 37, and 28 **pharmacists** per 100,000 people in Major cities, Inner regional, Outer regional, Remote and Very remote areas respectively.
- In 1999 there were 11, 9, 4, 4 and 2 **podiatrists** per 100,000 people in Major cities, Inner regional, Outer regional, Remote and Very remote areas respectively.
- In 1998 there were 62, 37, 32, 38 and 14 **physiotherapists** per 100,000 people in Major Cities, Inner Regional, Outer Regional, Remote and Very Remote areas respectively.

The prevalences described here by AIHW for other health professionals are the most recent that are available by Remoteness Areas. Unlike the situation for medical practitioners and nurses, there are no regularly released statistics on other health professionals. This is another matter on which the Alliance believes there should be greater equivalence across the various professional groupings.

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<sup>4</sup> *ibid*

### **The idea that Australia is ‘awash with doctors’**

Bob Birrell, from Monash University, has recently argued<sup>5</sup> that Australia is ‘awash’ with doctors, largely as a result of the importation of international medical graduates (IMGs).

The Alliance supports some of Birrell's findings. In particular he proposes that there should be a national and independent review to further assess: the situation regarding GP numbers, the use of IMGs, training of medical graduates in rural hospitals and general practice settings, apparent supervision and training inconsistencies between IMGs and medical graduates, assessment of IMG skills, and the effect of IMG-based bulk billing practices on the ongoing GP and hospital services in rural towns and on access for rural residents.

In short, Bob Birrell's arguments may be summarised as follows.

1. Because of shortages of doctors in many (often rural) areas, International Medical Graduates have been permitted to practise in ‘areas of workforce shortage’ after assessment of English language ability and medical knowledge (but not skills).
2. With about 6,000 IMGs working as GPs and Hospital Medical Officers (HMOs), the numbers in those workforce groups in rural and remote areas are considerably higher than they would otherwise be, although still less prevalent than in major cities.
3. Employers can sponsor as many IMGs to migrate to Australia as they like and each locally-trained and accredited GP may supervise up to four IMGs.
4. Because of the requirement to work in areas of workforce shortage, IMGs constitute a captive and therefore a relatively low-cost workforce.
5. Low-cost IMG doctors permit employers (including corporate general practices) to expand bulk billing and increase competition with non-IMG practices.
6. Practices staffed by Australian-trained GPs can supervise two GP registrars and therefore provide valuable training places for recent medical graduates/young doctors.
7. The number of medical graduates is increasing (from 1,287 in 2004, to 1,915 in 2009), with graduates increasingly competing with IMGs for positions as both HMOs and GP registrars. IMGs therefore face more competition for HMO positions and so are increasingly competing for positions in general practice,
8. Because the number of Australian-trained medical graduates is increasing rapidly, the intake of IMGs should be reduced.

There are a number of deficiencies in this analysis. Because many IMGs have completed or nearly completed their required time in rural areas, it can be expected that many of them will soon move to the major cities, creating further vacancies and shortages in the bush. So the current number and distribution of IMGs in rural areas is not a good indicator of the immediate future. This negative effect will be speeded up by the so-called ‘scaling’ of programs, which will see IMGs able to relocate after less than 10 years served in a remote or very remote area.

Birrell’s analysis does not take account of the older and less healthy population in rural and remote areas, which makes the application of simple national ratios inappropriate. Critically, because of the relative shortage of other health professionals, rural GPs have a scope of practice significantly broader than GPs in the major cities, often including providing medical services at the hospital. Many rural and remote GPs also spend significant proportions of

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<sup>5</sup> Birrell R, Australia’s New Health Crisis- Too Many Doctors. Centre for population and urban research. Monash University, September 2011. <http://arts.monash.edu.au/cpur/--downloads/australias-new-health-crisis.pdf>



their time travelling from one patient to another, so that the patient workload of one full time equivalent doctor at 40 hours a week is not the same in the major city as in rural and remote areas.

One of the Alliance's medical member bodies has written as follows:

“We are concerned at the use of such unrefined numbers as GPs per 100,000 people because it does not reflect the local need or the skill mix of the doctors. For example, where there is a procedural GP who undertakes anaesthetics, surgery and/ or obstetrics there is usually a colleague to undertake the complimentary skill, so at any one time there will be two doctors out of the practice for an emergency, obstetric or surgical case. What this means is that at times when there is an emergency and with two doctors in the town, they cancel and rebook the patients booked for consultations at the surgery and either the doctors come back from the hospital and work into the night clearing the backlog or they work longer the next day. Ideally, the town has a third and fourth doctor to pick up the load during an emergency.

The other side of the coin is that the procedural GP carries a different clinical load which does not equate to 4 or 6 patients an hour. Likewise GPs with hospital admitting rights and/or a nursing home patient load may be away from their practice 10 or 12 sessions per week. GPs with admitting rights may see hospital patients before or after 2 full sessions at the surgery.

GPs per 100,000 population and measures of FTE are insensitive measures of need without local data. Perhaps the establishment of Medicare Locals will give us the local data. One lives in hope.”

Birrell also discusses some of the issues relating to the assessment requirements of IMGs and Australian trained graduates, and the possibility that the numbers of IMGs in practice could be managed (ie increased or reduced) by redefining ‘districts of workforce shortage’ and ‘areas of need’ to adjust the number of places available to IMGs under special circumstances. These considerations are important in a different context but less relevant to this Senate Inquiry.

What is relevant, however, is what might be called ‘ratio creep’: the phenomenon which sees doctor-to-population ratios that were deemed acceptable some years ago no longer seen as satisfactory. Birrell makes the case that if a ratio of 1:1500 was acceptable in 2003, it should be now. A value judgement is needed for such a question, but certainly there is a greater proportion of people in Australia now with chronic disease than was the case eight years ago, and the average age of the population has increased, justifying a ratio somewhat lower than 1:1500.

The Alliance believes that questions of how much ‘doctoring’ Australia needs and the means by which it should be delivered (eg by GPs, specialists, practice nurses, midwives, nurse practitioners, physician assistants etc) are key issues. One of the Inquiry's major challenges will be to propose an acceptable ratio of doctors, nurses, midwives, allied health professionals, dentists, pharmacists and managers to population - and the extent to which the number will vary in different circumstances.

Rural and remote Australia is not awash with doctors, and there are as yet no certain signs that the shortage of GPs in the bush will be mitigated by the greater number of medical graduates in the pipeline. As ever, this will depend on how many of them choose to practise in rural areas.

### **Targeted incentives**

Better targeting can dramatically affect outcomes: The introduction of the muzzle loading percussion cap rifle and the 0.702 inch Minnie ball during the American Civil war, increasing the effective accuracy of small arms fire from less than 100 metres to more than 400, dramatically reduced the effectiveness of both massed infantry charges and canister/grapeshot from artillery, such that both became largely redundant.

Because rural areas are not awash with health professionals, nor soon likely to be, effective incentives are still needed to attract and retain doctors and other health professionals to rural and remote practice.

Currently, the ASGC-RA classification system is the basis for the targeting of incentives, and this is the source of much of the angst surrounding this policy issue. As outlined in the Summary above, the Alliance's view is that the ASGC-RA system is a necessary but not sufficient part of a functional definition of the rurality of particular places. The Alliance's 2008 paper to DoHA's review of geographic classifications is attached for the Inquiry's information (Attachment 7). It details why ASGC-RA is an excellent measure of remoteness, but insufficient on its own for the targeting of rural health programs.

There is a view that if the same range of financial and other incentives to locate rurally were available to all health professionals, whether trained in Australia or overseas, the invisible hand would do its work. And if the market rates of these incentives were not effective (ie not high enough), then they could be increased until health professionals moved in sufficient number for there to be equity. In this situation there would be a level playing field, for example, for doctors trained in Australia and overseas, but an uneven playing field (as now) between city and country areas. This could result in an even distribution of workers if only there were both the financial resources and the political will to tip the playing field sufficiently for enough to move.

The ASGC-RA system is more effective than the previous systems in the same way that the musket is better than the spear. However, its targeting is still very crude and a rifled system would produce much better results.

It is often wrongly assumed that ASGC-RA is a proxy for town size. Although the size of the town has an effect on the allocated RA classification, its effect is usually swamped in the algorithm used by the distances to the other population centres by which an RA score is determined.

The anomalies with the RA system can be demonstrated in the following groupings of places categorised in the same ASGC-RA group.

**RA 2** - Hobart, Dubbo, Coffs Harbour, Gundagai, Ulladulla, Tumut, Cobram, Tallangatta, Kingaroy, Rockhampton, Bunbury and York.

**RA 3** - Darwin, Cairns, Townsville, Moree, Urana, Wellington (NSW), Narrogin, Roma, Albany, Narromine, Ballimore, Mount Beauty, Swan Hill, Broken Hill, Geraldton, Burnie, Longreach and Balranald.

**RA 4** - Alice Springs, Mt Isa, Kakadu, Broome, Port Lincoln, Mallacoota, Bourke, South Hedland, and Walgett.

**RA 5** - Wilcannia, King Island, Maralinga, Lord Howe Island, Weipa and Horne Island.

Consider Townsville and Urana. Under ASGC-RA both are RA3. Under the previous system Townsville was RRMA 2, Urana RRMA 5. Townsville has a population of 170,000, is on the coast in north Queensland, has an annual mean rainfall of 45 inches and a broad economic base which includes service to the resources, fishing and pastoral industries, tourism and the public service (including a major army base and a university). Urana is in central-southern NSW, has a population of some 1500 people and is 375km from Melbourne and 566km from Sydney. Urana's population has been falling slowly for some years. It is small enough for most of its inhabitants to have a sense of place – and a house on one of its main streets can be purchased for \$65,000-\$90,000.

“Urana Shire presents a continuing gradual decline of population over the next five years as the rural sector adjusts to the potential impacts of less water and the global markets which drive the price of commodities. It is thought that the population will stabilise until the next impact is felt in the agricultural sector in maybe ten years’ time. Urana Shire’s population is projected to be approximately 1,170 in 2036.”  
Strengthening Basin communities, Stage 1 report; *Where are we now?* Prepared for Albury City, Corowa, Greater Hume and Urana Shire Councils.

### **Hypothetical case study**

Sue, a young GP, her husband Jeff (a solicitor) and her family are considering a move from Sydney to the country while the children (Jacinta and Rory) are still young and at primary school. The family are considering a move to either Urana in southern NSW or to Townsville - both classified Outer Regional (ASGC-RA3) and attracting the following incentives<sup>6</sup>:

#### Overseas Trained Doctors

The ten year restrictions will be reduced to seven years in ASGC-RA 3 localities.

#### HECS Reimbursement Scheme

Under the HECS Reimbursement Scheme, the HECS debts will be repaid over four years in ASGC-RA 3 localities.

#### General Practice Rural Incentives Program

The new General Practice Rural Incentives Program will provide the following incentives in ASGC-RA 3 localities:

- Relocation grants: Doctors who relocate from the city to ASGC-RA 3 localities may be eligible for a relocation grant of \$30,000.
- Retention grants: Doctors who practise in ASGC-RA 3 localities may be eligible for retention grants as indicated in the table below:

<sup>6</sup> <http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator>

Period of time in location (years)					
	1	2		3-4	5+
Grant amount	\$4,000	\$6,000	\$8,000	\$13,000	\$18,000

Urana has a population of 1500 and, on arrival, Sue will be the sole GP (unless another GP can be recruited). She will be working very hard; time off on the weekend and holidays will need to be planned well in advance so that locums (if available) or covering doctors from nearby towns<sup>7</sup> can be arranged. Jeff will have to drive three hours each day to and from Wagga to practise law, with a risk of high speed collision while travelling at dawn and dusk. They will need to make arrangements to ensure they are not locked out of the Sydney real estate market, as they intend to return to the city when the children start high school.

Townsville has a population of 180,000. Sue can work flexible hours in a group practice, and Jeff can work from home (or in an office close to home) and, should they wish, they can change their plans and stay indefinitely because there is a good selection of high schools and a university for Rory and Jacinta when they matriculate. Townsville also has a medical school where Sue can do some postgrad study.

The available incentives are not related to town size, which is in effect a proxy for the level of services and infrastructure available. While Sue may choose not to move to either Urana or Townsville, if the incentives were better targeted she would at least be more motivated to seriously consider the smaller place.<sup>8</sup>

The incentives available for rural practice should accommodate the increasing trend for doctors' families to prefer to know that they can stay in a more remote area for 2-5 years and then leave easily. A 'walk-in, walk-out' approach has been shown to work well, with a younger professional moving their family into the house vacated by the previous professional in town, with the practice already established, and with the knowledge that when they are ready to move on, they can pack up and leave.

## Recommendations

1. The ASGC-RA system should remain the building block for spatial classification systems used in the health sector, including for the distribution of incentives. For a revised system based on ASGC-RA to be widely accepted, the Federal Government needs to adopt the proposal made in this submission and put in place a 'fit-for-purpose' system for one or more particular purposes on which public reporting can be made. (In this matter, lessons can be learned from experiences with both PhARIA and the Alliance's amended use of ASGC-RA in its management of RAMUS.)

Notes to recommendation: A key criterion to be added for most specific purposes is town size. In all cases the basis of the system used should be the most up-to-date data from the ABS, as is currently used in ARIA+. (Note that PhARIA – which allocates incentives to rural pharmacists – is currently based on the much inferior ARIA, not ARIA+.)

<sup>7</sup> Jerilderie (40 mins drive), Lockhart (40 mins), Narrandera (1 hour), Henty (70 minutes), Culcairn (80 mins) or Corowa (60 mins).

<sup>8</sup> And she had better hurry up; because Dr John Baldeagle, an older GP with a keen eye for a bargain, an interest in the Jerilderie Grey Owl, a hatred for trees and fond memories of Urana as a young lad has already made his move and will commence work in Urana next week.

2. Given the significantly greater number of medical graduates now in training, it is crucial to check the rural medical incentives in place for their likely effectiveness with the new generation of graduates and junior doctors, and to put in place a revised set as appropriate. Rural incentives should then be targeted in the light of the characteristics of towns and individuals which lead to in- and out-migration to and from particular areas.

Notes to recommendation: There is already political pressure on the existing set of incentives from both ends of the spectrum: from those who believe they are ineffective (including due to the classification system used) and those who believe that the numbers of IMGs recruited should be cut. The slender evidence that already exists about factors which influence doctors' decisions to practise in rural/remote areas (rural origin, a supported rural placement, time in a rural primary school, a rural spouse) needs urgently to be updated in the light of the attitudes and expectations of new generations. Work should be undertaken urgently to establish the critical factors influencing health professionals moving to and not moving to certain towns, and the factors leading to decisions to stay in or move away from them (eg working hours, business arrangements, access to CPD and locums, family preferences). There might be a stronger emphasis on 'walk-in, walk-out' arrangements for GPs and other professionals.

3. This Senate Inquiry's findings and recommendations about the health workforce situation should not be based on simple ratios of health professionals to population. Instead, they must be based on a full appreciation of the differential health and social status of various population groups being served, and the vastly disparate characteristics of health professionals in different settings.

Notes to recommendation: The Alliance's firm belief is that Governments' actions on incentive programs for rural medical (and other) training, placements, relocation and retention, practice grants etc should also be guided by this stricture. Conclusions about workforce numbers and distributions based on false premises have the capacity for serious adverse consequences for certain population groups.

4. The Australian Institute of Health and Welfare (AIHW) should be mandated and equipped (including through appropriate resourcing) to produce regular published series on all major groups of health professionals, to add to the information already available for doctors and nurses, as well as health system and health status information. All such data series should be available by rurality (based on ASGC-RA).

Notes to recommendation: Despite significant improvements in data availability over recent years, there is still a paucity of data and evidence on allied health professionals, dentists, paramedics, trained health service managers, by geographical location, demographic characteristics, and on aspects of their training, support, scopes of practice and future intentions. Health Workforce Australia has some responsibilities in the data area but the work of the AIHW will remain critical. The activities of Health Workforce Australia and the AHPRA should provide a sound basis for improving this situation. One topic for particular attention is the likely number and distribution of IMGs over the next five years, given a range of scenarios relating to new arrivals and the likely intentions of IMGs already here.

**Further Recommendations**

Attachments 2 – 9 contain a range of Alliance recommendations from recent years, most of which still have currency and will be of interest to the Committee.